A RAND NOTE

MEDICARE AND MEDICAID: PAST, PRESENT, AND FUTURE

Kathleen N. Lohr, M. Susan Marquis

May 1984

N-2088-HHS/RC

Prepared for

The U.S. Department of Health and Human Services

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PREFACE

This Note was prepared as a background document for the Rand Health Sciences Program's investigations of health care financing issues. It is intended to serve as well as a reference paper for analysts concerned with the publicly funded health programs for the elderly and the poor (Medicare and Medicaid). Readers are cautioned that it surveys the history and prospects for these programs as they were seen in early 1984. The work was supported in part by the Rand Health Insurance Experiment grant (016B80) from the U.S. Department of Health and Human Services and in part by The Rand Corporation using its own funds.

SUMMARY

BASIC FEATURES OF THE MEDICARE AND MEDICAID PROGRAMS

The roots of Medicare and Medicaid can be traced to at least the Social Security Act of 1935. Issues of national health insurance have been debated vigorously since that time, turning mainly on administration (federal versus state), recipients (all individuals, or only all aged persons, or only all persons eligible for some form of a means-tested program), and method of financing. Medicare and Medicaid, enacted in 1965 as Titles XVIII and XIX of the Social Security Act, brought together these divergent views on medical care financing.

Medicaid adopted the principles of a means test for eligibility and state administration; it provides for federal matching amounts to state programs that pay certain medical bills of the needy. Part A of Medicare (Hospital Insurance [HI]) is a compulsory program of hospital insurance for the aged and disabled financed through the Social Security System. Part B of Medicare (Supplementary Medical Insurance [SMI]) is a voluntary medical insurance program, subsidized by the federal government through transfers from general revenues; it is available to the elderly and disabled upon payment of a premium. Eligibility criteria, benefits, and financing of Medicare and Medicaid are detailed in the text of this Note.

PROBLEMS WITH THE PROGRAMS

The overriding concerns about the future of these programs is economic: continued budget deficits at the national level and serious threats to state and county budgets, anticipated bankruptcy of the HI Trust Fund, and severe constraints on the ability of federal, state, or local governments to fund needed programs in other sectors of the economy. These problems have arisen in large measure from the seemingly excessive levels of health care expenditures and cost increases experienced in the nation over the past 15 years or so.

Evidence for the upward spiral in health care outlays comes in many forms. The average annual rate of increase in expenditures was 12.8 percent between 1965 and 1981, but it was 15.8 and 15.1 percent in 1980 and 1981 alone. The 6.0-percent share of the Gross National Product going to health care spending in 1965 is expected to double to 12.0 percent by 1990, and during the same period, public expenditures as a fraction of total health expenditures will have quadrupled. In 1981, federal outlays presented 12.2 percent of the federal budget, nonfederal expenditures 10.0 percent of state and local budgets.

Of particular concern is the rate of cost explosion for hospital care; such expenditures are estimated to rise about 25-fold between 1965 and 1990. These trends threaten to bankrupt the HI Trust Fund, with some pessimistic projections putting the first year of insolvency as early as 1984 and more optimistic ones as early as 1989. The Congressional Budget Office projects a possible cumulative deficit in the HI Fund of about $300 billion by 1995. The SMI Trust Fund does not face bankruptcy because of the required transfers from general revenues, but its rapidly growing outlays contribute heavily to overall federal budget deficits.

Other problems facing the programs include demographics (mainly the aging of the population), gaps in coverage of population groups (mainly that Medicaid by no means covers all impoverished persons), and lack of catastrophic protection against financial loss by beneficiaries. Fraud and abuse, especially in Medicaid, is perceived in some quarters as an important difficulty, and ensuring the quality of care delivered through these programs has also been a long-standing concern.

CHANGES IN THE PROGRAMS TO THE PRESENT

Modifications to the programs started almost immediately after the initial legislation was enacted, and most changes were aimed at controlling costs. Of particular importance were the 1972 Social Security Amendments (PL 92-603), which adopted a number of cost-control features and established the Professional Standards Review Organization (PSRO) program to curtail costs and improve quality of care. Attempts to encourage health maintenance organizations (HMOs) to enter into

contracts with Medicare have been made. For Medicaid, states have been given considerably greater flexibility in designing programs and defining eligibility criteria. Finally, fraud and abuse problems in both programs have been attacked through several laws.

Beginning in 1980, major pieces of legislation initiated a fundamental restructuring of these programs. The Omnibus Budget Reconciliation Act of 1981 (P 97-35) placed a number of restraints on Medicare payments. For Medicaid, it gave states much greater freedom to determine payments to providers, to define exceptions to the requirement that beneficiaries be allowed complete freedom of choice of providers, and to enter into prepaid arrangements with various provider entities. It also markedly lowered federal payments for Medicaid (by up to 4.5 percent by FY 1984).

The Tax Equity and Fiscal Responsibility Act of 1982 (PL 97-248, known as TEFRA) took sharp aim at controlling Medicare costs by establishing a cost-per-case reimbursement scheme and placing a ceiling on rates of increase in hospital revenues; thus, it effectively started Medicare hospital insurance move toward prospective reimbursement. It extended Medicare to federal employees, and it made major changes in audit, medical claims review, and utilization and peer review by establishing the Utilization and Quality Control Peer Review Organization (PRO) program as a substitute for the PSRO program. Finally, it expanded hospice coverage and improved incentives for HMOs to take in Medicare patients. TEFRA also gave the states permission to impose substantial copayments on most Medicaid eligibles.

Far and away the most revolutionary change was embodied in the Social Security Amendments of 1983 (PL 98-21), which established a prospective reimbursement mechanism for most inpatient hospital services covered by Medicare. Hereafter, hospitals must attempt to live within a prospective budget determined by prices established in advance on a cost-per-case basis, where case refers to one of 468 diagnosis-related groups (DRGs). After a three-year phase-in, DRG-specific prices will be uniform across the nation except for an adjustment for the hospital area's wage rate and its rural or urban location. PROs are expected to do utilization review (especially of admissions), quality-of-care monitoring, and validation of DRG classifications made by hospitals.

POTENTIAL CHANGES IN THE PROGRAMS

A wide variety of reforms of both Medicare and Medicaid are current topics of debate. For Medicare, they involve the following: tightening inpatient reimbursements from the HI Trust fund, constricting levels of SMI reimbursement to physicians, changing the benefit structure (e.g., increasing cost-sharing by beneficiaries, introducing a form of catastrophic cap on liability), modifying the way Medicare is financed, and giving Medicare beneficiaries vouchers to purchase private health insurance. Some proposals advocate restructuring the entire program by merging Parts A and B and combining aspects of the financing and cost-sharing arrangements.

Changes in Medicaid at the federal level involve facilitating the movement to case-managed care on a prepaid, capitated basis and improving the way long-term-care is financed (which affects Medicare eligibles as well). Other options include modifying eligibility for Medicaid, eliminating benefits, expanding cost-sharing, and giving states yet more flexibility in setting hospital rates and purchasing goods and services in high volume. The most fundamental proposed change is to federalize Medicaid, but this is very unlikely to be adopted in the near future.

ACKNOWLEDGMENTS

We are indebted to our Rand colleague Adele Palmer for constructive suggestions for improving the presentation and expanding the usefulness of this document for its intended audience. We thank Joseph Newhouse and Albert Williams for their usual unfailing support and advice. We are also grateful to Barbara Eubank for typing the report.

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I. INTRODUCTION

The looming crisis of the 1980s in controlling national outlays on medical care has prompted a wide variety of policy and research initiatives, especially at the federal level. Among the greatest concerns is the future of the major entitlement programs that finance health care for the elderly and the poor--Medicare and Medicaid. The Rand Corporation is undertaking a number of investigations relating to these issues, and in concert with those efforts we have prepared this background document.

The second section describes elements of the health care financing debate in the years before passage of the Medicare and Medicaid legislation and details features of the two programs through the 1970s. Section III discusses problems with the programs; particular attention is given to the alarming escalation in health care expenditures of the past few years and to selected problems such as demographics or gaps in coverage of services and population groups. Section IV outlines the main changes through the 1970s that were aimed at overcoming some of those problems.

Recent (and perhaps radical) modifications to the programs, especially those embodied in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the prospective payment provisions of the Social Security Amendments of 1983, are presented in Sec. V. Some of these changes will take until at least 1987 to implement fully, so this document can comment only on the state of affairs as of early 1984. Finally, proposed changes and reforms aimed at Medicare, Medicaid, or both, which can be expected to surface in policy debate over the next few years, are covered in Sec. VI.[1]

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[1]The reader interested in changes in the program occurring after this writing is referred to the *Social Security Bulletin*, a monthly publication of the Social Security Administration, and *The Medicare and Medicaid Data Book*, a periodic publication of the Health Care Financing Administration (Muse and Sawyer, 1982; Sawyer et al., 1983).

II. CONTEXT OF THE MEDICARE AND MEDICAID PROGRAM

THE EARLY YEARS

The roots of Medicare and Medicaid go back at least to the Social Security Act of 1935.[1] The public assistance provisions of the 1935 Act stipulated that federal matching funds could be used for medical care as an allowance included in monthly cash payments. Thus, although not providing direct payments for medical expenses, the 1935 Act extended the federal government's role in underwriting health care for the elderly. The Committee on Economic Security, in drafting the original plans for the Social Security system, had considered building national health insurance into the proposal. Fearing, however, that inclusion of compulsory national health insurance would jeopardize the entire program, the Committee excluded national health insurance from the draft plan but endorsed the concept in principle. Thereby began 30 years of debate about national health insurance, which would eventually culminate in the enactment of Medicare and Medicaid in 1965.

Bills proposing compulsory insurance for the entire population were introduced into Congress annually from 1939; national health insurance received public White House endorsement from President Truman in 1945. During this time, opponents of a federal role in the provision of health insurance for all persons offered counterproposals to aid states in providing health care for the needy.

At the heart of these debates were divergent views about financing. Proponents of compulsory national health insurance advocated a federally administered program, available to all persons, financed by earnings taxes. Proponents of a welfare-based system countered with means-tested proposals, administered by the states, financed by progressive taxes. Throughout, the American Medical Association (AMA) opposed any program of compulsory insurance for physicians' bills. The first outcome of the debate was adoption of the Social Security Amendments of 1950, which

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[1]This section is based on the following sources: Somers and Somers (1967); Corning (1969); Marmor (1970); Stevens and Stevens (1974); Davis and Schoen (1978); and Feder (1977).

provided for federal matching grants to states for direct payment ("vendor payments") to hospitals, physicians, and other medical providers for treatment of people on public assistance.

By 1950, proponents of federal health insurance had turned their attention to the health problems of the aged. The focus on the aged, with lower incomes yet higher medical expenses than the rest of the population, was intended to overcome arguments by advocates of a welfare-based system that national health insurance would help too many financially well-off persons. Furthermore, the 1950 amendments were effectively silent with regard to the aged not on public assistance who lacked sufficient resources to pay for their medical care. Finally, the growth in private health insurance coverage for the working population did not extend to protection for the aged.

During the 1950s, therefore, various proposals were introduced into Congress to use the Social Security system to provide hospital insurance for Social Security beneficiaries. These proposals excluded insurance coverage for physicians' services in an effort to forestall AMA opposition. Even with this narrowed focus, however, the issues of administration (federal versus state), recipients (all aged versus a means-tested program), and method of financing continued to be debated.

From this ferment emerged the Kerr-Mills Act of 1960 (actually, the Social Security Amendments of 1960, or PL 86-778, named for its main sponsors, Senator Robert Kerr and Representative Wylbur Mills). This Act expanded federal matching grants for medical payments for care provided to welfare recipients under old-age assistance. It also established a new category of vendor payments applying to the "medically needy"--the aged, blind, and disabled not on public assistance who had insufficient income to pay medical bills.

Despite passage of the Kerr-Mills Act, hospital insurance for the aged continued to be debated. It was an issue in both the 1960 and 1964 presidential elections. President Johnson's landslide election was seen as a popular referendum favoring such a program.

Early in 1965, the administration-supported plan for hospital insurance for the aged, financed by payroll taxes, was the first bill introduced in both the House and Senate. The Republicans offered an alternative proposal for subsidized, voluntary insurance for the aged;

it included coverage for physicians' services as well as hospital care and was to be financed outside Social Security. The AMA, in opposition to both plans, countered with a plan that basically expanded the Kerr-Mills legislation. In the midst of hearings by the House Ways and Means Committee on the alternative proposals, Chairman Mills devised a comprehensive package combining features of the three major proposals.

Mills's compromise plan was in its basic form enacted into law as Titles XVIII and XIX of the Social Security Act of 1965--Medicare and Medicaid. Part A of Title XVIII established a compulsory hospital insurance program for the aged similar to the administration-supported proposal financed through the Social Security system; Part B of Title XVIII provided a voluntary medical insurance program for the aged (modeled after the Republican proposal) subsidized by the federal government. Title XIX, Medicaid, reflected the AMA proposal by preserving the principles of a means test for eligibility and state administration of the program that had characterized the earlier welfare-based programs.

Table 1 summarizes the principal characteristics of the two programs; Table 2 presents their main benefits. In both tables, major program changes over time are noted. The rest of the section gives additional information about the programs as they developed over the ensuing 15 years. Even more detail can be found in annual supplements of the *Social Security Bulletin* (SSA, annual).

THE MEDICARE PROGRAM

Eligibles

Both parts of Title XVIII, or Medicare, began paying benefits for the aged in July 1966. When the program came into effect, all persons age 65 or older entitled to monthly Social Security benefits or payments from the Railroad Retirement system were enrolled in Part A, the Hospital Insurance (HI) program.[2] Voluntary enrollment in Part B, the Supplementary Medical Insurance Program (SMI), was available to any U.S. citizen 65 or over or any individual entitled to HI benefits upon payment of a premium.

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[2]During a transitional period, aged individuals with specified earnings credits short of those required for cash payments were also eligible for the HI program.

Table 1

SELECTED CHARACTERISTICS OF MEDICARE AND MEDICAID OVER TIME

Characteristic	Medicare Hospital Insurance (HI)	Medicare Supplemental Medical Insurance (SMI)	Medicaid
Title of Social Security Act	Title XVIII; Part A	Title XVIII; Part B	Title XIX
Principal Means of Financing	Payroll tax; proceeds placed in the HI Trust Fund	Premiums and transfers from general revenues; monies placed in SMI Trust Fund	Federal grants to states from general revenues
Basis of Reimbursement	Reasonable costs (1966-83); prospective payment on diagnosis-related groups (DRG) basis (begin 1983)	Reasonable charges	Hospital: Medicare reasonable cost basis (1966-81); left to states (begin 1981) Other providers: left to states
Main Cost-Sharing Arrangements	Hospital inpatient annual deductible; copayment for day 61 and over Skilled nursing facility; copayment for day 21 and over	Annual deductible ($50, 1966; $60, 1973; $75, 1982) and 20% of remainder	1973: Categorically needy: "nominal" copayments allowed for optional services; Medically needy: "nominal" copayments allowed for all services.
Main Eligibility Specifications	1966: All persons 65 or older entitled to monthly benefits from Social Security or Railroad Retirement 1973: Persons with end-stage renal disease; persons under 65 entitled to monthly disability benefits from Social Security or Railroad Retirement Voluntary for persons aged 65 or older, enrolled in SMI but not otherwise eligible for HI, with payment of a premium	Voluntary for any U.S. citizen aged 65 or over or any person entitled to HI benefits upon payment of a premium	Determined by states, but must include cash assistance recipients; could also include specified groups (e.g., the categorically related medically needy)

Table 2

MAIN BENEFITS OF MEDICARE AND MEDICAID OVER TIME

Medicare		Medicaid	
HI	SMI		
BENEFITS IN 1966			
Inpatient hospital services 90 days in a benefit period	Benefits for physicians' and surgeons' services	Mandatory services:	Optional services:
	100 home health visits	Inpatient hospital care	Other services could include home health care; clinic services; dental services; private duty nursing; physical therapy; prescribed drugs, dentures, eyeglasses, etc.
Outpatient hospital diagnostic testing	Other medical services including diagnostic tests, rental of durable equipment and supplies	Outpatient hospital services	
		Laboratory and x-ray services	
100 days of post-hospital skilled nursing care		Skilled nursing home services	
100 post-hospital home		Physicians' services	
BENEFITS ADDED OR CHANGED AFTER 1966			
Additional 60 days of inpatient hospital services (lifetime reserve days)	Physical therapy in a facility or at home	Mandatory services:	Optional services:
	Purchase of durable equipment	Rural health clinic services	Intermediate care facility services
Unlimited post-hospital home health visits	Limited optometric and chiropractic services	EPSDT services	Inpatient psychiatric hospital services
Hospice benefits	Unlimited home health visits	Family planning services	Inpatient services for persons institutionalized for TB or mental disease
	Speech pathology services		
	Outpatient hospital diagnostic testing transferred from HI to SMI		
	Services in rural clinics		

The 1972 Social Security amendments (PL 92-603) extended Medicare coverage to persons under 65 entitled to monthly disability benefits for 24 months[3] under Social Security or Railroad Retirement and to persons with end-stage renal disease. Voluntary enrollment in HI was also made available to individuals age 65 or over enrolled in SMI, not otherwise eligible for HI, with payment of a hospital premium.

Benefits

The HI program initially provided benefits for inpatient hospital services for 90 days in a benefit period (subject to a deductible and copayment for days 61 to 90); outpatient hospital diagnostic testing (subject to a $20 deductible and 20 percent coinsurance); 100 days of post-hospital skilled nursing care (subject to copayment for days 21 to 100); and 100 post-hospital home health visits. The SMI program paid benefits for physicians' and surgeons' services, 100 home health visits, and other medical services including diagnostic tests, rental of durable equipment, and supplies. Benefit payments under SMI were subject to a $50 deductible and 20 percent coinsurance.[4]

During the 18 years since the programs were enacted, benefits under the two Medicare programs have been modified. Under the HI program, benefits have been added for an additional 60 days of inpatient hospital services (subject to copayment), which can be used if the 90 days of coverage in a benefit period are exhausted ("lifetime reserve days"), for unlimited post-hospital home health visits, and for hospice care. Under SMI, benefits have been added for: physical therapy given in a facility and furnished by a therapist in the office or patient's home (currently subject to a $500 maximum), purchase of durable equipment, limited optometric and chiropractic services, unlimited home health visits, and speech pathology services.

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[3]The 1972 amendments required 24 *consecutive* months of entitlement to disability benefits. This restriction was dropped in 1980 (PL 96-499).

[4]The deductible paid for outpatient hospital diagnostic tests under the HI program counted as incurred expenses under SMI.

The 1972 Social Security Amendments eliminated the SMI deductible and coinsurance for inpatient services of radiologists and pathologists (although they would be reinstated under TEFRA); the coinsurance requirement for home health care was eliminated in 1972 and the deductible in 1980. The SMI deductible for other services now stands at $75, having been increased to $60 by the Social Security Amendments of 1972 and to its current level by the Omnibus Budget Reconciliation Act of 1981. Finally, payments for outpatient hospital diagnostic testing were transferred from the HI program to the SMI program by the Social Security Amendments of 1967.

Financing

The HI program is financed primarily by a specific payroll tax. Other financing comes from the Railroad Retirement system, from premiums paid by the elderly who voluntarily enroll in the HI program, and from interest on funds not used for current expenses that are invested in federal securities. These monies are deposited into the HI Trust Fund, from which reimbursement for benefits and administrative expenses is made.[5]

The payment provisions of the 1965 Act specified that hospital reimbursements were to be based on *reasonable cost*, not charges. At the time Medicare was enacted, cost reimbursement was officially endorsed by the American Hospital Association (AHA) and Blue Cross; the latter was the largest third-party payer for hospital services and generally reimbursed on the basis of cost. Thus, to gain industry support for the Medicare plan, the designers of the Act adopted cost-based reimbursement for the HI program.

Under the HI program, each hospital nominates a *fiscal intermediary* (FI) for its claims processing.[6] This intermediary computes the hospital's reasonable cost according to program regulations.

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[5]Administrative responsibility for Medicare (and the federal part of Medicaid) resides with the Health Care Financing Administration (HCFA), which was established within the Department of Health, Education, and Welfare (DHEW) in 1977. DHEW was itself reorganized several years later and became the Department of Health and Human Services (DHHS), as it is currently known.

[6]Fiscal intermediaries (carriers in Part B, fiscal agents in

"Reasonable cost" refers to those costs actually incurred in providing health services to beneficiaries; however, the Medicare statutes and regulations specify the kinds of costs that Medicare will allow. Hospitals must accept Medicare reimbursement as payment in full and bill patients only for the deductible, copayment, and any personal services. Actual payment for claims is based on an interim rate established between the hospital and the intermediary. Year-end adjustments in reimbursement are based on cost reports submitted by the provider to the intermediary.

The SMI program obtains funds from premiums paid by (or on behalf of) the insured, from general revenues, and from investment interest. These monies are deposited into the SMI Trust Fund, also administered by DHHS. The initial legislation set premiums to finance one-half of the benefit and administrative costs of the SMI program. However, the 1972 legislation provided that premiums could be raised by no more than the percentage increase in monthly Social Security cash benefits. Currently, premiums cover 25 percent of program costs. TEFRA established that through July 1985, premiums would be allowed to rise to continue to cover 25 percent of program costs, after which time the premium calculations would revert to the previous method.

Carriers are nominated by the SMI plan administrators to serve as intermediaries with providers. Reimbursement for services under SMI is based on *reasonable charges*, which are the lesser of the provider's customary charge for the service, the prevailing charge in the locality for similar services, or the charge applicable to policyholders or subscribers of the carrier for comparable services.[7] Physicians who enter "assignment" agreements with Medicare accept the Medicare

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Medicaid) are contractors with the federal government (or state for Medicaid) that process or pay claims. Typically, FIs in Medicare are insurance companies, such as the Blue Cross Association, which may in turn subcontract to member plans such as Blue Cross of California.

[7]The "customary charge" is the provider's median charge for a procedure over the prior 18-month period. The "prevailing charge" is the 75th percentile of customary charges of all physicians in a given specialty in a designated area; however, since 1972 the rate of increase in the prevailing charge has been tied to an economic index. For more detailed definitions and information on reasonable cost and reasonable charge determination, see Subcommittee (1976); Weiner (1981); and Muse and Sawyer (1982).

reasonable charge determination as full payment for the service. Physicians who do not enter such agreements may bill the patient for any excess over the Medicare reasonable charge.

The original Medicare legislation allowed prepaid group practice plans to contract directly with Medicare for Part B covered services. Reimbursement was to be based on the allowed costs for services actually rendered. Furthermore, any prepaid group practice plan that owned its own hospital was allowed to serve as the hospital's intermediary under Part A.

In 1972, Congress authorized risk-basis contracts for Health Maintenance Organizations (HMOs).[8] Under such contracts, the HMOs' end-of-year allowed costs per Medicare member were to be compared to the estimated cost to Medicare for comparable beneficiaries in the fee-for-service system (the Average Adjusted Per Capita Cost or AAPCC). If actual costs per member were lower than the AAPCC, the HMO could retain one-half of the savings above 80 percent of the AAPCC to a maximum of 10 percent of the AAPCC.[9] If actual costs exceeded the AAPCC, the HMO had to absorb the difference. Medicare enrollees in risk-basis HMOs were "locked in" to the plan; that is, they could not receive Medicare reimbursement for out-of-plan use. HMOs could also continue to contract with Medicare on a cost basis--Medicare enrollees in cost-contracting HMOs may use, and receive Medicare reimbursement for, out-of-plan services. Prepaid plans that accept Medicare beneficiaries but do not contract directly with Medicare are called "carrier dealing" plans; they receive reimbursement through the routine Medicare fee-for-service billing procedures.

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[8]The literature on HMOs is voluminous. Interested readers are referred to Luft (1981) or Brown (1983) for authoritative background.

[9]Characteristics of risk-basis contracts were changed by the TEFRA legislation. The changes are discussed in Sec. V.

THE MEDICAID PROGRAM

Eligibles

Medicaid provided for federal matching grants to state-administered programs that give medical assistance to the needy (see Table 1). To qualify for federal assistance, state plans had to include, at a minimum, persons who receive cash assistance payments. In addition, states were authorized (not required) to include specified groups for whom federal matching payments were available: those who would be eligible for categorical programs if the state adopted the broadest coverage allowed by law; those who would be eligible if not in a medical facility; and the "categorically related medically needy," i.e., those who meet criteria for categorical assistance except for income but who do not have sufficient resources to pay for their medical care.

The 1972 Amendments (PL 92-603) also affected Medicaid by making more uniform among the states the definition of who among the aged, blind, and disabled were eligible to receive Supplemental Security Income (SSI) payments. The states retained, however, some flexibility in deciding who within that group would be covered by the state's Medicaid program.

Benefits

State Medicaid plans were required to cover, through vendor payments, inpatient hospital care, outpatient hospital services, laboratory and x-ray services, skilled nursing facility (SNF) services, and physicians' services. These are usually referred to as "mandatory" services (as shown in Table 2). Required services added since the original legislation include rural health clinic services, early and periodic screening, diagnosis, and treatment (EPSDT) programs, and family planning services.

States could also receive matching grants for other ("optional") health services. These initially included medical or remedial care furnished by other licensed practitioners, home health care, private-duty nursing, clinic services, dental services, physical therapy, prescribed drugs, dentures, eyeglasses, and other diagnostic screening services. Several optional services have been added since Medicaid was enacted (see Table 2).

The *amounts* of mandatory and optional services were never specified in the law. States were free to impose limits on coverage, but all mandatory services had to be offered for a plan to qualify.

The 1965 legislation required states to develop a plan with comprehensive benefits by 1975. It also provided for state Medicaid programs to "buy-in" to the Medicare SMI program on behalf of eligible recipients over age 65; in this instance, the states pay the SMI premium and copayments.

Financing

Medicaid is a joint federal and state program, so both levels of government share in the costs. Federal payments are made on a "matching" basis from general revenues.

Following the Medicare provisions, Title XIX specified that reimbursement to hospitals under Medicaid was to be on the basis of reasonable cost as specified in the Medicare regulations; however, the formula for reimbursing other providers was left to the states. Vendor payments are of course made directly to providers, who must accept Medicaid reimbursement as payment in full.

The law did not require states to develop a Medicaid program. However, the legislation provided that there would be no further matching funds under Kerr-Mills after 1969, thus putting considerable pressure on states to develop a Medicaid plan.[10]

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[10]All states except Alaska and Arizona developed programs by the deadline. Alaska subsequently established a Medicaid program in 1972, leaving Arizona as the sole state without a program (until very recently).

III. PROBLEMS WITH THE PROGRAMS

Although Medicare and Medicaid share some fundamental problems and face some unique ones, the overriding common concern is economic. Fears about financial disaster center on three areas: continued budget deficits at the national level and serious threats to state and county budgets; anticipated bankruptcy of one of the Medicare Trust Funds; and severe constraints on the ability of federal, state, or local governments to fund needed programs in other sectors of the economy. These issues are discussed in the next subsection.

Apart from the economic issues, a number of other problems have faced these programs nearly since their inception. These include evolving demographic characteristics of the U.S. population, inequities caused by gaps in coverage of people or services, and fraud and abuse. The second subsection ("Other Problems Facing Medicare or Medicaid") takes up these topics in more detail.

THE UPWARD SPIRAL IN HEALTH CARE EXPENDITURES

Increases in Health Expenditures

These problems arose in large measure from the seemingly excessive levels of health care expenditures and costs experienced over the past 15 years or so. Table 3 gives some illustrative information for selected years.[1] In 1965, as the nation embarked on these two programs, health expenditures totaled $42 billion; a quarter of a century later, the figure is expected to reach $756 billion. In per capita terms, the equivalent figures are $211 and $2982.

Absolute levels of health expenditures are not in themselves as alarming as the *accelerated* rate of growth in those expenditures. The average annual rate of increase between 1965 and 1981 was 12.8 percent: 12.4 percent for 1965-1970; 12.2 percent for 1970-1975; 13.4 percent for 1975-1980. In 1980 and 1981 alone, national health expenditures rose 15.8 percent and 15.1 percent, respectively.

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[1]Estimates and forecasts of expenditures in the text or Table 3 are taken from Waldo and Gibson (1982, especially Tables 1 and 8) and Freeland and Schendler (1983, especially Tables A-5, A-6, and A-18), unless otherwise noted.

Table 3

SELECTED DATA ON HEALTH CARE EXPENDITURES
SINCE 1965 AND PROJECTED TO 1990

Dimension of Expenditure	Actual		Projected	
	1965	1981	1983	1990
Total health care expenditures ($ billions)	42	287	362	756
Per capita health care expenditures ($ thousands)	211	1225	1521	2982
Health expenditures as a % of GNP	6.0	9.8	10.4	12.0
Total public health expenditures ($ billions)	10.8	105.4 (1980)	151.1	324.7
Public expenditures as a % of total health expenditures	10.8	42.3	41.7	43.0
Federal outlays ($ billions)	5.5	83.9	104.2	231.6
State/local outlays ($ billions)	5.2	38.6	46.9	93.1
Medicare outlays ($ billions)	1.1	44.7	63(a)	110(a)
Medicaid outlays ($ billions)	1.5	31.3	NA	NA
Hospital expenditures ($ billions)	13.9	118.0	154.7	340.1
Number of active physicians	288,700	449,500	493,000	591,200

(a) Estimated from Rivlin (1983).

The nation's economy has not expanded at an equivalent rate. The average annual percentage increase in the Gross National Product (GNP), for instance, was only 7.5 percent for 1965-70, 10.2 percent for 1970-1980, and 8.9 percent and 11.6 percent for 1980 and 1981. Predictions for the near future (1980-1990) suggest that total health expenditures may grow by 11.7 percent, the economy by only 9.1 percent.

These figures mean that the share of the GNP going to health care spending has also jumped. For example, the 6.0-percent share of GNP in 1965 is expected to double to 12.0 percent by 1990 (see Table 3).

For many experts, the issue of greatest concern is the fraction of the total health care bill underwritten by public funds. With the inception of Medicare and Medicaid in 1965, the share of the bill paid by individuals or by private insurance dropped and the share paid by government, especially federal and state, rose dramatically. In 1965, total public expenditures were $10.8 billion; by 1990 they may have tripled (Table 3). Over the same period, public expenditures as a fraction of total health expenditures will have quadrupled (Table 3).

The *rates* of increase in public financing of health care have generally outstripped overall rates of increase in health care spending. The average annual percentage increases in total public spending were 20.8 percent for the five years following the introduction of Medicare and Medicaid and 14.3 percent for the 1970-1980 period; they are expected to be 11.9 percent for 1980-1990.

Within the public sector, *federal* outlays have climbed steadily (Table 3); from 1965 to 1981, the average annual rate of growth was 18.5 percent. By 1981, the federal share of health spending was 29.2 percent. Projections for 1990 (based on assumptions about the effects of TEFRA, but not about the effects of prospective payment using Diagnosis-Related Groups (discussed below)) place the federal share at 30.7 percent.

The share of expenditures borne by *state and local governments* did not rise as sharply during this same period (moving from 12.6 to 13.5 percent), but the amounts coming from those nonfederal public sources are still large. Although the percentage share is projected to drop by 1990 (to 12.3 percent), the dollar amount will more than double.

Just as national health expenditures are taking an ever-larger portion of GNP, so are health outlays absorbing more and more of the budgets at the federal, state, and local levels. In 1965, federal expenditures represented 4.4 percent of the federal budget, and nonfederal public expenditures 7.0 percent of state and local budgets; by 1981, the figures were 12.2 percent and 10.0 percent, respectively. The problem for states is particularly acute because for those with large welfare populations, Medicaid "remains the largest consumer of public expenditures under state aegis" (Iglehart, 1983b, p. 870).

Increases in Program Expenditures

Of course, Medicaid and Medicare are not the only health programs with a claim to public funding, but they are by far the largest and, not surprisingly, have shown enormous expansion over the past 15 years. Federal outlays for Medicare and Medicaid in the first full year of the programs (1966) totaled $1.87 billion (about 25 percent of all federal program expenditures), and net state and local payments for Medicaid totaled another $0.78 billion (13 percent of all expenditures at those governmental levels). By 1981, the combined Medicare/Medicaid figures were $62.3 billion (74 percent of federal health outlays) and remaining Medicaid payments were $13.8 billion (36 percent of state and local health spending).

Increases in Hospital Expenditures

Of particular concern is the significant place that *hospital care* has in this picture of health cost explosion. Expenditures for hospital care (see Table 3) were 33 percent of all national health expenditures in 1965, 41 percent in 1981. Projections based on TEFRA assumptions place hospital expenditures as high as $340.1 by 1990, representing 45 percent of total health expenditures. In the quarter-century, then, hospital expenditures might rise by almost 25-fold!

These alarming trends will bankrupt the Medicare Trust Funds, specifically the HI Trust Fund, within a few years. Estimates prepared by the Social Security Administration (Svahn and Ross, 1983) show the HI Trust Fund in 1982 with an income of $38 billion and an outgo of $36.1;

equivalent projected figures for 1989 are $74.4 and $85.5, making 1989 the first year in which the HI Trust Fund would be depleted. (Less optimistic assumptions about the state of the economy put the first year of depletion in 1984.) Estimates from the Congressional Budget Office (CBO) differ only in detail; they suggest that the HI Trust Fund is expected to be insolvent by 1988 and to have run up a cumulative deficit of about $300 billion by 1995 (Rivlin, 1983). The SMI Fund does not face bankruptcy per se, because of legislatively mandated transfers from general revenues to cover any shortfalls; its rapidly growing outlays, however, contribute to overall federal budget deficits that are viewed as unacceptable over the long run.

Factors Underlying the Cost Explosion

Several factors account for the problems facing Medicare and Medicaid.[2] In both cases, general price inflation in the economy has contributed enormously to the rapid rise in hospital costs. Price rises in the past decade or so, especially for employee salaries and nonlabor inputs to hospital care, probably account for half the higher costs. A second factor is simply how the country pays for care: Most analysts agree that the near-total reliance on third-party payers (at least for hospital care) interrupts the traditional relationships between supply and demand that might otherwise restrain use and thus expenditures.

A third factor is the "agency" role of physicians, who (as "the captain of the team" (Fuchs, 1974)) constitute an important group for creating demand for health care (on behalf of their patients) and thus for determining the size of the health care sector (Enthoven, 1981). Partly because of unrelated federal policies encouraging higher

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[2]Causes of and explanations for the spiral in health expenditures in this country have been the subject of many articles, books, and monographs over the past decade, and they are too numerous to list here. The interested reader is referred to the following publications or compilations (apart from the items cited throughout this Note): Zubkoff (1976); Somers and Somers (1977); Jonas and contributors (1977); Altman and Blendon (1979); Russell (1979); Enthoven (1980); Meyer (1983); and the quarterly issues of the *Health Care Financing Review*. For works that consider the bioethical implications of allocative decisions and economic constraints in health care, see Beauchamp and Walters (1978), especially Part IV; Shelp (1981), especially the chapters by Engelhardt and Childress; or President's Commission (1983).

enrollments in medical schools, the number of active physicians (including both doctors of medicine and doctors of osteopathy) will have doubled between 1965 and 1990 (see Table 3). Accordingly, the number of persons per physician will have dropped from 658 (in 1965) to 515 (in 1981), 483 (in 1983), and 429 (in 1990).

Finally, some analysts argue that new technology and increased per capita provision of services (i.e., greater intensity of services) have contributed to cost increases in these programs. Although changes in payment systems may alter the financial incentives favoring technology-intensive practice, many observers expect other forces to continue to promote the rapid spread and use of new technologies. These forces include the education system for training physicians, social pressure to adopt new technologies (especially curative ones), competition among hospitals to attract physicians, and obstacles to and lags in the evaluation of new technologies (Schroeder and Showstack, 1979).

None of these factors, except perhaps reliance on third-party payers, is likely to change in the near future. Thus, they can be expected to continue to be problems for the Medicare and Medicaid programs, because all will continue to exert upward pressure on costs.

OTHER PROBLEMS FACING MEDICARE OR MEDICAID

Demographics

One challenge for both programs is the changing composition of the population by age and income. The growth and increasing age of the beneficiary population in Medicare may account for almost 20 percent of the projected growth in Medicare outlays up to 1995 (Rivlin, 1983). In 1960, about 9.2 percent of the U.S. population was 65 years of age and older; in 1980, 11.3 percent fell into that age bracket. By 1990, 12.6 percent of the population is expected to be that age.

The Medicare-eligible population is itself aging. In 1965, about 37 percent of those 65 and older were actually 75 and older. In 1983, the fraction is expected to be 41 percent and, in 1990, 43 percent (Freeland and Schendler, 1983). For persons who were 65 years of age in 1978, the average expectation of life was an additional 16.3 years, up more than 1 year of additional life from the expectation for persons who were 65 in the earlier part of the 1970s (NCHS, 1980; 1983).

These population figures have implications chiefly for the Medicare program, especially with respect to anticipated increases in intensity and costs of services owing to the greater prevalence of chronic disease and incidence of serious illnesses common to the elderly. However, they are certainly not insignificant for Medicaid, because of that program's responsibility to cover the aged, blind, and disabled who are eligible to receive SSI benefits and because that program represents the major public insurance program for long-term care.

The size of the wage-earning population is of concern to Medicare because the HI Trust Fund is financed mainly through a payroll or earnings tax. As the population ages, we can expect a proportional drop in the wage-earning sector--those between 16 and 64. The CBO (Rivlin, 1983) estimates that taxable earnings will grow much more slowly than hospital costs (7 percent versus 13 percent). Thus, even with a rise in the tax rate itself (which will grow to 1.45 percent each for employees and employers in 1986), funding from this source will not keep pace with expenditures.

With respect to Medicaid, the fraction of the population below the poverty line was relatively steady (at between 12.6 percent and 11.6 percent) for the decade of the 1970s (SSA, 1982). Just over one-fifth of persons at this income level are children under 18 years in families headed by women (i.e., the traditional Aid to Families with Dependent Children (AFDC) category that constitutes about 60 percent of Medicaid eligibles); just under one-sixth are persons 65 and older. The proportion of the population living in poverty has started to rise recently; for example, it was higher in 1982 than 1981, especially for persons under 15 years of age (Welniak and Fendler, 1983). This trend may slow as the recent recession eases up, however.

Gaps in Coverage

Other difficulties facing Medicare and Medicaid are less easy to quantify. The programs have not been fully successful in sparing the elderly and the poor from burdensome out-of-pocket expenses. These problems arise because of gaps in the coverage of certain population groups and gaps in benefits. Redressing these imbalances (see Sec. VI

for some current proposals) would require additional outlays in a time of serious budgetary pressures.

Gaps in Coverage of Population Groups. By no means does Medicaid cover all impoverished persons. The ratio of Medicaid recipients to persons living below the poverty level ranged from 115 percent (Massachusetts) to 24 percent (several states) in 1979 (Muse and Sawyer, 1982). Davis and Rowland (1983a) reported that of those with incomes below 125 percent of the poverty line, over one-quarter are uninsured and of those considered "near-poor," about one-fifth are uninsured.

The reasons that many poor persons are not covered by Medicaid are numerous. For instance, some states establish income thresholds far below the poverty level or do not adjust cutoff points for inflation. Some states "enfranchise" a categorically needy group beyond that mandated, others a "medically needy" group, but in all cases the groups tend to be defined differently by state (see, e.g., Muse and Sawyer, 1982). The great flexibility states have in defining income and resource requirements, eligibility, benefits, covered services, and provider payment schemes leads to inequities in the treatment of persons with equal needs.

Furthermore, not all states have participated in Medicaid, and of those that do, a number have obtained waivers of various federal regulations governing payment mechanisms or scope of benefits offered to some but not all eligibles. Only recently did Arizona even join the Medicaid program, with its "experimental" AHCCCS program (Arizona Health Care Cost Containment System) to develop and test an alternative payment and delivery system that relies on prepaid capitated financing, competition among providers, and a network concept of primary case management.

Gaps in Benefits. Medicaid services differ by state. As noted in Table 1, certain services must be covered: e.g., inpatient and outpatient hospital care provided by or under the direction of a physician, and services from SNFs, physicians, laboratories, and rural clinics. The number and scope of optional services vary enormously by state (Muse and Sawyer, 1982). The EPSDT program is a good example of how "mandatory" services can differ by state, because states are allowed to determine what services, apart from vision, hearing, and dental care,

will be made available and to define what is meant by screening and diagnosis. The program has been confined to basically a screening operation in many states (Cannon, 1981).

Such gaps in benefits coverage also occur in Medicare (although they do not differ by state). Outpatient prescription drugs, dental care, private-duty nursing, and various other services are not covered at all. Only recently were unlimited home health visits covered.

Catastrophic Coverage. A third gap, common to both programs, is the lack of catastrophic coverage. Medicare, for instance, puts an upper limit on the number of hospital days an elderly person will be covered (90 days in any one benefit period plus the 60 days of lifetime reserve). Analogous limitations apply to inpatient tuberculosis and psychiatric hospital services and to inpatient care in skilled nursing facilities.

Moreover, patients with "rare" diseases or diseases that can be treated only with extremely expensive tertiary care (such as transplants) may not be eligible to have that care reimbursed through Medicare, if the treatment is still considered experimental or is simply not yet recognized (or certified) as a reimbursable service. The main exception is for persons (of any age) suffering from end-stage renal disease, nearly all of whom are eligible for complete coverage of dialysis or transplant costs.

Fraud and Abuse

Fraud and abuse are perceived as enduring difficulties with the Medicare and (especially) the Medicaid programs. The proportion of Medicaid funds paid for ineligible patients or uncovered services in 1976-1977 was reported to be as high as 49 percent in one locality and to be as high as 25 percent for several states; a special computer-based monitoring effort was instituted to identify extreme "outlier" providers (Iglehart, 1982a). Senate hearings in the late 1970s highlighted the problem of "Medicaid mills" and very large Medicaid practices, and the scandals of serious underservice and other questionable practices that marked the state network of "prepaid health plans" in California's Medi-Cal program left lasting impressions of a widespread need for reform.

Legislation passed in 1972 (PL 92-603) and 1977 (PL 95-142) was specifically designed to overcome some of the more egregious problems. Among other things, provisions prohibited providers from assigning claims to others, reformed payment procedures, forbade illegal remuneration (bribes, kickbacks), and specified penalties against fraudulently secured benefits and misrepresentation of the condition of facilities to qualify for reimbursement.

Although fraud and abuse are believed to add materially to the costs of these programs, that contention has never been completely substantiated. Rogers et al. (1982) argued that the net cost of these problems "is apparently not enough to raise the costs of the program per person above the cost of medical care per capita for comparable non-recipient Americans" (p. 16). Mitchell and Cromwell (1980) reported that most "large Medicaid practices" (those in which at least 30 percent of the patients are Medicaid-eligibles) did not appear to be Medicaid mills; they did not earn excessive fees, overuse ancillary services, skimp on auxiliary staff, or enforce excessive markups over costs, although providers tended to be less well credentialed than physicians in other private practice. Efforts to detect and remove instances of fraud and abuse on the part of both providers and beneficiaries will doubtless continue, but they are not likely to be of great importance in attacking the root causes of the programs' mounting costs.

Quality of Care

Ensuring the quality of care delivered through these programs has also been a long-standing problem (see Lohr and Brook, 1984, for a historical review). Professional Standards Review Organizations (PSROs) were established by 1972 legislation (PL 92-603) to control Medicare and Medicaid costs (through utilization review, principally of hospital inpatient care) and improve the quality of care. The PSRO program had a particularly stormy history, in large measure because Congress expected it to be mainly a cost-containment effort, whereas the Executive Branch and the medical profession saw it more as a quality-of-care activity.

Programwide evaluations emphasized what PSROs did (or did not) accomplish by hospital review in producing desired reductions in hospital stays and costs of federal health programs. The evaluations were somewhat contradictory and incomplete. They suggested that the PSRO program probably saved about as many resources as it consumed, but that these savings fell short of expectations (or were brought about partly by shifting system costs to privately insured patients).

Little systematic evaluation was done of the effects of the PSRO program on quality of care. In general, however, improvements in a number of areas of medicine were documented over the years, some involving overuse of services (e.g., intermittent positive-pressure breathing services or blood transfusions) and some involving underuse of services (e.g., preoperative visits by anesthesiologists and pulmonary disease testing).

The TEFRA legislation (PL 97-248) (discussed below) scuttled the PSRO program and replaced it with a "Utilization and Quality Control Peer Review Organization" (PRO) program. In areas where no PSRO was (or is) currently functioning, Medicare fiscal intermediaries were to (and do) perform these review activities. The Medicare Prospective Payment System (PPS) legislation (PL 98-21) (see below) required that hospitals under the PPS must contract for review services with the state's PRO and have such a contract by October 1984 as a condition for continued Medicare reimbursement.[3]

The new PROs are substantially different from PSROs: PROs are contracts, not grants; PROs can be for-profit organizations (such as fiscal intermediaries and insurance carriers); the representation by private-practice physicians can be very low (perhaps no more than 5 percent of providers in the area); and all their funding will come from the Trust Funds (none from appropriations). Further, standards of evaluation explicitly emphasize the degree to which PROs are able to

[3]As of this writing, final regulations governing the PRO program had not been issued, and it was not clear what steps might be taken to extend the PSRO program. Consequently, the position of hospitals as regards the requirement that they have a PRO contract in place was ambiguous at best. From a practical standpoint, the Medicare fiscal intermediaries will carry out the review activities that PROs were expected to perform.

hold down hospital admissions; relatively little is said about what PROs are expected to do in the quality-of-care arena. Most observers expect that the major quality-of-care issues that PROs will need to address on behalf of the Medicare program concern underservice, given the financial incentives of the PPS in that direction (Smits, 1981).

Low Reimbursement Levels

One paradox of the Medicare and Medicaid programs is that although costs have skyrocketed, reimbursement levels are perceived by providers as too low. Less-than-full reimbursement of charges has had the effect of restraining the participation of some providers in one or the other program, particularly Medicaid (Iglehart, 1983b). In the case of coverage of physician services to the elderly, Medicare reimburses only 80 percent of reasonable costs (after the annual deductible paid by the patient) for providers who take assignment. For those claims for which the physician does not accept assignment, the Medicare allowance is less than 75 percent, meaning that Medicare payment in this situation may equal only about 58 percent of the total physician bill (Iglehart, 1982b).

IV. CHANGES IN THE PROGRAMS TO THE END OF THE 1970S

MEDICARE

Concern about rising Medicare costs, particularly for the HI program, was evidenced as early as 1967. In the Social Security Amendments of that year, Congress authorized experimentation with alternatives to Medicare's cost-based reimbursement in a search for payment methods to offer incentives for efficiency.

During the 1970s policymakers adopted a number of strategies designed to control Medicare costs. For the most part, the controls were aimed at changes in payments to providers rather than reductions in benefits, although the SMI deductible was increased twice since 1965.

The 1972 Social Security Amendments (PL 92-603) adopted a number of cost-control features including: authorizing establishment of reimbursement limits for routine operating costs (so-called Section 223 limits); paying hospital charges where charges were less than costs; withholding reimbursement for depreciation and interest attributable to capital expenditures that had not been approved by a state planning commission; tying increases in prevailing charges (used to establish the "reasonable charge" level under SMI) to an economic index; and specifying penalties for kickbacks, bribes, rebates, and misrepresentation. (As noted earlier, the 1972 amendments also established the PSRO program in an effort to hold down hospital costs through utilization review of inpatient care.) New restrictions on payments to providers serving beneficiaries in both Medicare and Medicaid were also adopted in 1980 (PL 96-499) to control costs, for example by limiting reimbursement for markups added by physicians for billed laboratory tests.

The 1972 law defined procedures for HMOs to enter into "risk-basis" contracts with Medicare. Before the 1972 amendments, HMOs and other prepaid plans had been reimbursed for Medicare beneficiaries on the basis of costs, and such plans had been very reluctant to enter into agreements with Medicare because of the divergence between Medicare reimbursement and their usual accounting practices. The 1972 policy

changes were designed to encourage HMOs to enroll Medicare beneficiaries, but as noted in Sec. II, HMOs could retain only 10 percent of the difference between their costs and the AAPCC. Thus, the incentives to achieve savings were weak and risk-basis contracts based on the 1972 legislation were and continue to be unattractive to HMOs. As of March 1981, only one HMO had elected a risk contract, although several HMOs were under special demonstration-project risk contracts.

In the mid-1970s, legislation was designed to overcome cost problems associated with fraud and abuse in both Medicare and Medicaid. In 1976, PL 94-505 established the Office of Inspector General in DHEW to carry out investigations and audit of all DHEW programs, including Medicare and Medicaid. In the following year, PL 95-142 increased the penalties for fraud and abuse established in the 1972 legislation, further defined illegal practices, and provided federal funds to states to establish an office to prosecute cases of Medicaid fraud.

In sum, Medicare cost-control efforts during the 1960s and 1970s focused on limiting provider payments within the basic reimbursement system established in the 1965 legislation. Not until the 1980s would a major restructuring of the reimbursement system occur.

MEDICAID

As enacted in 1965, Medicaid provided for open-ended federal matching grants to states and left cost control to the states. When it early became clear that the program would cost far more than initial estimates, the federal government began to adopt new legislation to control costs. In contrast to the cost-containment legislation for Medicare, however, initial changes in the Medicaid program not only affected payments to providers but also tightened eligibility criteria and restricted the scope of benefits.

For example, the Social Security Amendments of 1967 tied means-test levels for Medicaid to the means-test for cash assistance in each state. Federal matching grants for the medically needy were to be available only for families whose income did not exceed 133.3 percent of the income limit for those on cash assistance. "Spend down" provisions allowed the income basis to be defined as income after out-of-pocket medical expenses had been deducted. The 1967 amendments allowed states

to impose coinsurance or deductibles for inpatient care on the medically needy. Furthermore, for the medically needy the mandatory requirement that states provide five basic services was overridden by a provision that states need provide only seven of the 14 mandatory and optional services.

Other cost-control measures included in the 1967 legislation involved licensing nursing homes used by Medicaid recipients and periodically reviewing the medical needs of patients in nursing homes to prevent overuse of such care. Federal matching funds for intermediate-care facilities were authorized to encourage use of this less expensive alternative to skilled nursing care facilities. The legislation required states to enter agreements with all Medicaid providers that they submit to audits as deemed necessary. States were also charged with taking all reasonable efforts to collect any payments due from other third parties, and the federal government was to receive its share of any such collections. Finally, the 1967 legislation moved away somewhat from a vendor payment program and allowed for direct payments for physicians' and dentists' services to the medically needy, with the beneficiary then liable to the provider.

While the 1967 legislation tightened eligibility requirements and restricted the scope of benefits in some areas, it also provided for new benefits and a new category of beneficiary. The latter was the "essential" person, defined as the spouse of a cash assistance recipient essential to the recipient's welfare. New mandatory benefits added in 1967 included the EPSDT program for children under age 21 and home health services for certain groups.

The 1972 amendments adopted cost-control measures aimed at Medicaid as well. Some provisions adopted for Medicare (discussed above) also applied to Medicaid: denial of reimbursement to hospitals for depreciation and interest on certain capital expenditures, specified penalties for fraud, and utilization review by PSROs. Tighter review of nursing home use was encouraged by reducing federal matching payments for long-term care to states that had inadequate programs to control use of such services or that failed to audit institutionalized patients. The federal matching share for long-term-care payments was held at 105 percent of payments in the previous year. States were also allowed to

impose nominal deductibles and copayments on the medically needy for mandatory and optional services and on the categorically needy optional services.

To encourage cost-effective forms of delivery, the 1972 law waived requirements adopted in the 1965 Act requiring statewide comparability in the provision of care to all Medicaid beneficiaries; with DHEW approval states could provide more generous health services through prepaid comprehensive programs. States were also free (subject to DHEW approval) to determine "reasonable cost" reimbursement to hospitals, divorcing the determination from Medicare regulations.

The 1972 amendments gave states some flexibility in determining eligibility for Medicaid for the aged, blind, and disabled who were receiving cash assistance payments under the new SSI program. States whose cash assistance standards for such individuals were more restrictive than the new SSI criteria were free to apply the more restrictive criteria in determining Medicaid eligibility. However, the criteria had to apply to income less SSI payment less out-of-pocket medical expenses.

The original Medicaid legislation established a goal for states to devise comprehensive care programs by 1975. The 1969 Social Security Amendments retained the concept of a comprehensive program but extended the deadline, and the 1972 amendments eliminated the requirement entirely.

Although the 1972 amendments were aimed at controlling costs, some new benefits were provided by the legislation. Family planning services were made mandatory, three-month retroactive coverage was required for persons found eligible, and recipients were also allowed to carry benefits for four months after Medicaid would normally terminate because of increased family income.

V. RECENT CHANGES IN THE PROGRAMS

Current or proposed changes to the Medicare and Medicaid programs take two main forms: legislation and "experimental" or "demonstration" activities allowed by virtue of waivers of usual eligibility, benefits, or payment mechanism requirements. The more important recent legislation affecting one or both of these programs has been the following: the Omnibus Budget Reconciliation Act of 1981 (PL 97-35), the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (PL 97-248), and the Social Security Amendments of 1983 (PL 98-21), specifically Title VI (Prospective Payments for Medicare Inpatient Hospital Services). Because these acts are so far-reaching, we have itemized their more important features below. For further background, see OTA (1983), Svahn and Ross (1983), and SSA (1983).

Waiver and demonstration programs are by definition not uniform across the nation, the states, or the two programs, and are far too numerous and complex to describe here. For information on some activities that have been in operation for several years, see Galblum and Trieger (1982), Gibson (1983), Iglehart (1983a), and a description of research and demonstration projects of the Health Care Financing Administration (HCFA, annual publication).

OMNIBUS BUDGET RECONCILIATION ACT OF 1981

Medicare

This act had several provisions important to Medicare beneficiaries. It eliminated the carryover from the previous year of incurred expenses for meeting the Part B deductible and, more importantly, increased the Part B deductible by 25 percent (from $60 to $75). It also made Part A coinsurance current with the year in which services were furnished (not when the spell of illness began) and raised the Part A deductible and copayment by changing the base year for the calculations. The legislation placed a variety of limitations on reimbursements, including constraints on the routine nursing differential, outpatient services, hospital services (beyond 108 percent

of the average per diem routine operating cost), home health agency services, and renal dialysis services (to encourage home dialysis).

Medicaid

The provisions of the 1981 Reconciliation Act applicable to Medicaid were even more striking. To give greater flexibility to the states, the law modified the requirement that Medicaid eligibles be allowed to obtain services from any qualified provider, by authorizing new exceptions to the "freedom-of-choice" requirement. For example, it allowed a state to "lock-in" a beneficiary (by restricting the choice of provider by any Medicaid recipient who has overused services) and to "lock-out" (or limit) the participation of any provider who has provided medically unnecessary services or poor quality of care. States could request a waiver of the freedom-of-choice requirement and as of August 1982, 15 states had done so, mostly under an authority relating to primary-care networks.

In a move that affected the states very significantly, the law reduced federal payments for Medicaid by 3 percent in FY82, 4 percent in FY83, and 4.5 percent in FY84. Those reductions were relaxed in certain instances: if the state had a qualified hospital cost review program, if the state had a high unemployment rate, or if the state had made substantial progress in fraud and abuse recoveries. Nonetheless, the effect was to curtail the federal share of covering medical care for the poor quite substantially.

PL 97-35 gave further freedom to states to determine bases for hospital reimbursement. The 1972 amendments had permitted states to adopt alternatives to the Medicare reasonable-cost formula. The 1981 legislation totally divorced the Medicaid calculation from Medicare and authorized states to use their own methods and standards to make "reasonable and adequate" payments.

The 1981 law expanded the states' flexibility to define "medically needy" and determine what services would be provided to that group. For example, states covering the medically needy are no longer required to cover all beneficiary categories; however, if a medically needy program exists, it must provide ambulatory care to children and prenatal care to pregnant women. It also markedly curtailed AFDC eligibility (and hence

automatic Medicaid eligibility) by tightening requirements for cash assistance.

To encourage alternative delivery systems, the new legislation allowed states to enter into prepaid arrangements with entities other than federally qualified HMOs and to establish minimum enrollment periods for up to six months, for which federal matching funds would be available for the full period even if Medicaid eligibility ended. Previously, matching funds had been available for recipients who enrolled in an HMO only while they were eligible for Medicaid; frequent changes in Medicaid eligibility status had made HMOs reluctant to participate in Medicaid. Finally, to promote other forms of less expensive care, matching funds were authorized for home- or community-based services for persons who would otherwise require institutionalization.

TEFRA

TEFRA (PL 97-248) had a number of significant provisions that affected Medicare and Medicaid. The main elements of the law are noted below and in Table 4: some additional details follow.

Medicare

The provisions of this law that pertain to Medicare were aimed directly at controlling costs. The most important established a cost-per-case basis for reimbursement and placed a ceiling on rates of increase in hospital revenues. Although these stipulations are effectively repealed by overriding provisions in the Prospective Payment System (PPS) mechanism established by PL 98-21 (see below), they remain significant because they figure prominently in how much hospitals will be reimbursed prospectively in the early years of PPS. A number of other cost-control measures affected Part A and Part B providers.

In one controversial arena, TEFRA extended Medicare coverage to all federal employees who previously had not been eligible. It also made Medicare secondary to employment-based insurance for certain employees ages 65 to 69.

Table 4

MAJOR PROVISIONS OF THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT
(PL 97-248)

MEDICARE-RELATED

1. Modified hospital reimbursement policies: (a) Section 223 limits were extended to include ancillary costs applied on a cost-per-case basis and adjusted each hospital's limit by a case-mix adjustment; (b) a 3-year limit was established for the rate of increase in hospital revenue (where the limits would cease upon implementation of a prospective payment system); and (c) hospital payment was allowed under a state-established hospital reimbursement control system (if the system applied to at least 75 percent of hospital inpatient revenues and to the state's Medicaid program and met certain other requirements).

2. Established a single reimbursement limit for skilled nursing facilities (SNFs) and home health agencies based on the cost experience of freestanding facilities.

3. Eliminated the routine nursing salary cost differential for both hospitals and SNFs.

4. Limited the reasonable charge for the services of physicians who perform services in hospital outpatient departments to a percentage of the amount of the prevailing charge for similar services furnished in a physician's office, taking into account whether overhead costs of the department have already been included in the hospital's costs or charges.

5. Stipulated that costs incurred by a hospital or SNF in complying with the free-care provisions of the Hill-Burton Act could not be considered reasonable costs for purposes of Medicare reimbursement.

6. Required a more precise distinction to be made between professional services rendered to individual patients and reimbursable under Part B on a "reasonable charge" basis and professional services of general benefit to patients reimbursable only on a "reasonable cost" basis.

7. Eliminated the 100 percent reimbursement rate for inpatient radiology and pathology services and placed them on the same basis as other physicians' services (80 percent of reasonable charge after deductible has been met).

8. Prohibited reasonable charge reimbursement for assistants at surgery in certain circumstances (largely exceptional medical problems).

9. Implemented a provision of PL 97-35 that prohibited use of Medicare Part B funds to pay for drugs that the FDA determined to be less than effective in use. (This provision applies to Medicaid as well.)

10. Required employers of 20 or more persons to offer their employees age 65-69 (and dependents) the same health care benefits offered to younger employees. Medicare's payments were then to be secondary to the employment-based insurance for these older workers and spouses.

11. Required that Medicare coverage be extended to federal employees, who would have to pay the HI portion of the Social Security tax.

12. Eliminated the requirement of a 3-day prior hospitalization before "post-hospital extended care services" in an SNF so long as that would not increase costs or change the acute-care nature of the SNF benefit.

MEDICAID-RELATED

1. Permitted states to impose "nominal" copayments in all cases except for services provided to certain persons in the categorically and medically needy categories (e.g., children under 18, institutionalized persons who have spent down their income to the personal-needs allowance) or for certain services (pregnancy-related, emergency and family planning services, all services from an HMO for categorically needy eligibles). Also allowed the Secretary of DHHS to waive various copayment provisions to allow for demonstration projects to be conducted.

2. Strengthened the ability of the state to impose liens on property of institutionalized Medicaid recipients and enabled states to impose a penalty of ineligibility for Medicaid for 24 months on such persons who transfer their homes for less than full market value. (An error in drafting the change relating to transfers may effectively nullify it.)

3. Stipulated that federal matching funds to states with eligibility error rates in excess of 3 percent would be reduced by the amount of the excess erroneous expenditure (except in selected circumstances when the Secretary of DHHS can waive this penalty).

4. Allowed states to give Medicaid coverage to disabled children age 18 or under who live at home but who would have been eligible for SSI (and thus Medicaid) had they been institutionalized, provided that home care is no more expensive than institutional care would have been.

TEFRA made other major changes in audit, medical claims review, and utilization and peer review. The most significant was to establish the PRO program as a substitute for the PSRO program. (Differences between the PRO and PSRO program were discussed above.) It substantially expanded the provision of hospice care to terminally ill beneficiaries, recognized hospices as distinct providers, and established that hospice reimbursement be made on the basis of reasonable cost within a cap equal to 40 percent of the estimated average Medicare expenditures for cancer patients during the last six months of life; it also required the Secretary of DHHS to issue a report about the feasibility of prospectively reimbursing hospices and about the effectiveness of the hospice demonstration program. Finally, TEFRA authorized prospective reimbursement under risk-sharing contracts with HMOs and other eligible organizations at a rate equal to 95 percent of the AAPCC (the estimated cost of providing services to similar Medicare beneficiaries in the same geographic area who are not enrolled in the HMO), which represented an improved incentive for these prepaid arrangements to take in Medicare patients.

Medicaid

Fewer TEFRA provisions related to Medicaid, but they were also significant (see Table 4 for more detail). The most stringent involved giving the states permission to impose copayments on most Medicaid eligibles.

PROSPECTIVE PAYMENT SYSTEMS FOR MEDICARE--THE 1983 AMENDMENTS

Far and away the most revolutionary change in the federally financed health care programs is the one establishing a prospective reimbursement mechanism for most inpatient hospital services covered by Medicare. The legislation (PL 98-21) directly attacks the economic incentives that motivate hospital behavior, because hospitals must attempt to live within a prospective budget determined by prices established in advance on a cost-per-case basis (rather than rely on retrospective reimbursement of such costs). The major features of PL 98-21 are given in Table 5.

Table 5

MAIN PROVISIONS OF PROSPECTIVE PAYMENTS FOR
MEDICARE INPATIENT HOSPITAL SERVICES
(TITLE VI OF PL 98-21)

1. Pay hospitals a price per discharge based on 1 of 468 diagnosis-related groups (DRGs).

2. Phases in PPS over a 3-year, cost-reporting period in which payment rates are based on a blend of hospital cost experience and national and regional DRG amounts for urban and rural hospitals:

First period
25% of regional DRG rate
and
75% of hospital cost rate

Second period
50% of national/regional
(25/75) DRG rate
and
50% of hospital cost rate

Third period
75% of national/regional
(50/50) DRG rate
and
25% of hospital cost rate

Effective with hospital accounting periods beginning October 1, 1986, the Medicare payment will be 100 percent of the national urban or rural DRG rate.

3. Considers prospective payments payment in full, and hospitals can have no recourse to beneficiaries for payment beyond the allowable deductible and coinsurance.

4. Allows payments for both cost and length of stay "outliers," with total payments for outliers confined to between 5 to 6 percent of total Medicare outlays for inpatient care.

5. Requires Medicare inpatient hospital costs incurred under PPS to be "budget neutral" (neither more nor less than they would have been under TEFRA provisions).

6. Applies PPS to most short-term general hospitals serving Medicare patients; the exceptions (e.g, psychiatric, children's, rehabilitation, and long-term-care hospitals) continue to be reimbursed under TEFRA limits. Gives special consideration to hospitals that are sole community providers and to those that serve specialized populations

(low-income, rural patients needing treatment in referral centers, cancer research patients).

7. Requires all nonphysician services provided in the hospital setting, which previously might have been billed under Part B (SMI), to be covered as Part A services.

8. Invokes specific formulas for calculating allowable inpatient operating costs per discharge for FY83, FY84, and FY85; beginning with FY86, specifies that annual increases will be determined by the Secretary of DHHS, with guidance from a Prospective Payment Assessment Commission that was also established by this legislation.

9. Requires DRG classifications to be recalibrated in FY86 and every 4 years thereafter, based in part on recommendations from the Commission, taking into account changes in treatment patterns, technology, and other related factors.

10. Excludes expenses for capital projects, return on equity, and medical education from PPS.

11. Requires hospitals to maintain a system of cost reporting essentially until the end of FY88.

12. Allows or requires Medicare payments to be approved for hospitals in states that have a cost-control system, provided that the system meets a number of requirements (some from the TEFRA legislation and some new).

13. Requires hospitals to contract with a PRO for review services, with such a contract being a condition for Medicare payment beginning in FY85.

14. Mandates a wide variety of studies and reports to Congress. Topics include: capital-related costs; an annual impact report (for 1984 through 1987); impacts on SNFs; impacts on admissions; feasibility of extending DRG payment to cover (a) physician charges for services to inpatients, (b) presently exempted hospitals, (c) all inpatient hospital payers, and (d) hospitals in Puerto Rico and the Trust Territories; phasing out separate urban/rural DRG rates; factors to use in compensating hospitals for outliers and to use in modifying DRGs by severity of illness; and ways to minimize incentives to increase admissions.

PPS went into effect for all hospitals beginning at the start of accounting years on or after October 1, 1983. The main elements of PPS involve a three-year transition into a national set of prices for hospital care, based on 468 Diagnosis-Related Groups (DRGs), that will be adjusted only for the hospital area's wage rate and its rural or urban location. (Point 2 of Table 5 gives these formulas.) The new system gradually overrides TEFRA, which had begun to move the entire Medicare program from retrospective cost-based reimbursement toward prospective DRG payment; it is expected to be fully implemented by FY87.

Briefly, the pricing system works as follows.[1] All Medicare discharges are classified into one of the 468 DRGs (Fetter et al., 1980). Each DRG has a weight that is intended to reflect its relative resource consumption (Pettengill and Vertrees, 1982). The initial weights were computed on the basis of data from the Medicare Statistical System for 1981 (augmented in some cases with data from Maryland and Michigan for low volume DRGs); the weights will be adjusted periodically.[2] The actual payment for each discharge is determined by multiplying a standardized payment rate by the DRG weight.

During a transition period, total payment for a discharge is a blend of a hospital-specific payment, a regional payment, and a national payment (see Table 5); thus, there are also hospital-specific, regional, and national payment rates. The hospital-specific standardized payment rate is based on the hospital's costs for the 12-month period ending on or after September 30, 1982, adjusted for the hospital's case mix and updated for cost inflation.[3] The regional and federal payment rates are

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[1]The regulations governing this revolutionary change in Medicare are voluminous and exacting. Interim regulations appeared in the *Federal Register* of September 1, 1983 (pp. 39752-39890) and final regulations in the *Federal Register* of January 3, 1984 (pp. 234-340).

[2]As of September 1983, the DRG with the highest weight (6.8527) is DRG 104, "Cardiac valve procedure with pump and cardiac catheterization." The one with the lowest weight associated with a condition pertinent to Medicare (0.2071) is DRG 465, "After care with history of malignancy as a secondary diagnosis." (The one with the lowest weight overall (0.1842) is DRG 382, "False labor.") DRG 103, "Heart transplant," has a weight of 0. DRGs 469 and 470 contain cases that either have a procedure diagnosis that is unacceptable as a discharge diagnosis or are ungroupable, and both have weights of 0. For the entire list with weights, see the September 1, 1983, *Federal Register*.

[3]This rate excludes capital costs and direct costs of medical education, which are still reimbursed on a cost basis.

averages of the hospital standardized amounts, adjusted for variation in hospital wage levels and grouped according to rural or urban location. National and regional standardized rates are reduced to account for outlier payments (see below). For fiscal years 1984 and 1985 a further adjustment is made in all three rates to achieve budget neutrality with respect to aggregate payments that are estimated would have been made under prior legislation.

The pricing system applies to all inpatient admissions except for a small number with unusually long lengths of stay or unusually high costs ("outliers"). Some hospitals are exempted, at least initially, and all hospitals in some states with their own cost-control systems ("waiver states," such as New York and California) are also exempted.

The law established a Prospective Payment Assessment Commission that will be responsible for making recommendations to the Secretary of DHHS about DRG recalibration and other facets of the system. Finally, it specified a role for PROs in utilization review (especially with respect to admissions), quality-of-care monitoring, and validation of DRG classifications that are derived from the diagnostic and procedure information that hospitals provide.

VI. POTENTIAL CHANGES IN THE PROGRAMS

FUTURE MODIFICATIONS TO MEDICARE

As implied by the list of topics that require demonstrations to be conducted or reports to be prepared within the next three years (see Table 5), a number of decisions about yet further changes in Medicare lie ahead. Many of the proposed changes are presented by Rivlin (1983), K. Davis (1983), C. K. Davis (1983) for the present administration, and the Congressional Budget Office (CBO, 1983). Others have been explored by analysts on behalf of the Subcommittee on Health of the House Ways and Means Committee (Committee, 1983).

One such issue is how much inpatient reimbursements from the HI Trust Fund should be tightened, in the sense of keeping them some percentage (e.g., 9 percent) below the level they would have been had payments continued to be based on actual costs. Decisions in this arena may require changes in the formula (derived from TEFRA and budget neutrality requirements) that will be used to calculate increases in reimbursements for 1984 and 1985.

Payment rates for years beyond 1985 might be allowed to grow by only "market basket plus 1," where "market basket" refers to the rate of increases in prices hospitals must pay for labor and nonlabor inputs and "1" refers to an additional percentage point to cover technological advance (Ginsburg and Moon, 1983; Lave, 1983); this level of reimbursement, it is estimated, would reduce the HI Trust Fund deficit in 1995 from $250 billion to $93 billion (Ginsburg and Moon, 1983). Some consideration might be given to making that formula even more stringent. Increasing payment rates by "market basket minus 1.6" has been estimated to maintain solvency of the HI Trust Fund through 1995 (Ginsburg and Curtis, 1983). However, possible serious regional dislocations in the continued operation of existing hospitals and adverse impacts on access for Medicare patients may make such restraint in the growth of payment rates undesirable.

A second issue is how to affect levels of SMI reimbursement for physicians. This issue will call for choices among a variety of possible changes in the structure or manner of paying physicians, such as applying more stringent limits to the growth of "reasonable charges," applying PPS and DRGs to physicians (at least for inpatient care), establishing fee schedules for particular types of services or physicians, or requiring physicians to accept assignment (i.e., not allow them to bill patients beyond the Medicare-recognized level). Current proposals from the administration include freezing Medicare reimbursements to physicians immediately (for one year), which presumably allows some time for consideration of extending PPS to physicians. Fox (1983) has proposed market-areawide incentives and targets with a reward and penalty structure related to whether actual Medicare expenditures are above or below target levels.

A third area of concern involves potential changes in the benefit structure. These might take the form of increased cost sharing for Medicare beneficiaries across the board, greater cost sharing for specific services such as each hospital day, or cost sharing related to ability to pay. Various proposals have suggested increasing the SMI premium or instituting an HI premium. One option under consideration at the moment includes indexing the Part B (SMI) deductible to the Medicare Economic Index (such that it would rise to $100 by CY88); another involves increasing the SMI premium by setting it to cover 25 percent of projected expenditures in CY84 and raising it in stages until it covers 35 percent of projected expenditures (to approximately $32/month).

In general, proposals related to raising the exposure of beneficiaries to costs of care are tied to proposals to introduce some form of a catastrophic cap on liability for hospital bills. For example, the present administration proposes to increase cost sharing in the early days of a hospitalization (especially days 2-15) but lower the cost sharing in the latter days of care in an SNF (days 21-100), eliminate any cost sharing (deductible and coinsurance) after the 60th day of hospitalization in any one year, and restrict the imposition of a deductible to twice a year. Hsiao and Kelly (1983) have outlined reforms to replace uniform deductibles and coinsurance with cost-sharing

amounts that vary with "provider cost categories" and to limit cost sharing to an income-related maximum liability.

Fourth, rather than continue to modify payment mechanisms, benefits, or cost-sharing requirements, policymakers could choose to attempt to change the way Medicare is financed, mainly by increasing taxes. Several options (or combinations) have been put forth. For example, the earnings tax that now underwrites the HI Trust Fund (paid by both employers and employees) is scheduled to rise from 1.3 percent of earnings (up to $35,700) to 1.35 percent in 1983 and to 1.45 in 1986 (and thereafter to 1995). The rate could be raised, but some estimates (C. K. Davis, 1983) show that to keep the HI Fund solvent over the next 25 years, it would have to be increased to 4.3 percent (roughly 2.15 percent for employers and employees)--about a 50 percent rise in the rate.

Another option is to transfer funds from general revenues to help underwrite HI outlays (which is not currently allowed) and to maintain SMI outlays as well. Because SMI payments are expected to grow much faster than federal tax revenues, such transfers might place an unsupportable demand on this financing source, thereby provoking a need for either higher income tax rates or new or higher taxes of other sorts. In this latter category would fall excise taxes on alcohol and cigarettes, perhaps earmarked for Medicare (Long and Smeeding, 1983; Stettner, 1983).

The administration and others have also proposed to limit the amount of tax-free insurance that employers can provide (before the medical insurance benefit is included in the employee's taxable income). This is viewed as a means of raising income tax revenues that might then be used to offset, say, SMI outlays, apart from whatever effect it would have on curtailing use of medical care in the general population.

Fifth, yet another possible change is to offer Medicare beneficiaries the option of using a voucher to purchase private health insurance, with the voucher having the value of 95 percent of the cash value of Medicare. This is essentially an extension of the provision of PL 98-21 that permitted Medicare payments on a risk basis to HMOs and other competitive medical plans. In theory, protection against excessive cost sharing would be built in, so that no beneficiary would

purchase coverage less extensive than that provided by Medicare. Some analysts would make the voucher system mandatory rather than voluntary (Friedman et al., 1983); Medicare beneficiaries would be able to choose care from various "alternative health plans" and to share in any savings of costs of care.

The CBO (1983) recently studied the probable impact of a variety of optional changes in Medicare's benefit structure. Options included (a) increasing the SMI premium; (b) instituting an HI premium; (c) increasing the SMI deductible; (d) increasing the SMI coinsurance rate (to 25 percent); (e) adding hospital coinsurance of 10 percent of the deductible amount (beginning with day 2 and eliminating the current cost-sharing requirements), perhaps with a variety of ceilings, including some that are income-related; and (f) several "combination" options involving SMI premiums and/or coinsurance on inpatient, SNF, home health care, or SMI-covered services. Their simulations showed that, in general, instituting an HI premium or adopting one of the combination options involving hospital coinsurance and SMI premiums or coinsurance produced the greatest savings to the federal budget (from $2.3 to $2.5 billion in FY84), at an increased cost for all elderly persons of between $112 and $120 per person. Raising the SMI deductible or modifying the hospital coinsurance rate with a protective income-related ceiling produced the least savings (under $1 billion a year) but imposed additional out-of-pocket costs on the elderly of only about $10 to $15 a year.

Although not directly a reform of Medicare, proposals to make the purchase of so-called "Medigap" supplementary insurance policies by the elderly seem less attractive are also being voiced. Such a change is prompted in part by the belief that such coverage induces greater use of Medicare by vitiating the effects of cost sharing (Link et al., 1980). The impact on federal outlays of the purchase of supplementary insurance is estimated to exceed $3 billion per year (Ginsburg, 1983). Some analysts suggest levying a tax equal to the amount of additional costs to Medicare engendered by supplemental coverage (Ginsburg, 1983; Long and Smeeding, 1983); others note that major benefit and structural reforms in Medicare as a whole might reduce the demand for supplemental

protection. The provision of information and advice to the elderly under the auspices of HCFA is being undertaken as well (Stettner, 1983).

Finally, some experts advocate a more radical reform of Medicare. K. Davis (Davis, 1983; Davis and Rowland, 1983b), for instance, proposes that the HI and SMI parts of Medicare be merged, effectively making SMI compulsory rather than optional. The combined trust fund would be financed by both payroll taxes and general revenue transfers; other reforms in financing might include an income tax surcharge levied on beneficiaries that would effectively replace the SMI premium with a premium for the entire program (which is thus income-related). Cost-sharing provisions would be simplified by imposing only a single deductible and coinsurance for all services; more importantly, a maximum ceiling on cost-sharing would be instituted. Other modifications would include: keeping increases in prospective payments to hospitals under tight rein; requiring physicians to take assignment and to be paid according to fee schedules; and extending Medicare coverage to all persons 65 and older and to all disabled individuals now covered.

PROPOSED CHANGES FOR MEDICAID

As emphasized elsewhere, Medicaid is an extraordinarily complex program because of the many dimensions that are effectively under the control of the states. We have deliberately not tried to summarize the many ways that the 54 Medicaid programs differ from each other. Thus, the discussion that follows is focused mainly on changes that might be contemplated at the national (federal) level.

The most remarkable change currently underway for Medicaid is case-managed care on a prepaid, capitated basis. The Robert Wood Johnson Foundation (cosponsored by DHHS and the National Governors' Association) has established a $9.6 million Prepaid Managed Health Care Program to underwrite grants to providers who will deliver care on a prepaid, primary-care-managed basis (Iglehart, 1983a). A number of states have begun to restructure their own Medicaid programs by turning to prepayment and primary-care case management and by simultaneously restricting Medicaid recipients in their choice of providers (Gibson, 1983).

California, for instance, negotiates with Medicaid (Medi-Cal) providers on the basis of price and restricts eligible persons to those selected. A number of other states (e.g., Oregon, Massachusetts, Michigan, Colorado, Kentucky, and New York) have elected to try case-management systems for Medicaid, with the enthusiastic support of DHHS. Recently Arizona joined the Medicaid program, with its "experimental" AHCCCS program to develop and test an alternative payment and delivery system that relies on prepaid capitated financing, competition among providers, and a network concept of primary case management (Vogel, 1983).

Reforming the way the costs of long-term care are financed is considered a high-priority problem for Medicaid (and Medicare), because of the increasingly large share of the Medicaid budget that goes for nursing home services (as much as one-half of the Medicaid budget in many states (Paringer, 1983)). Some options in this area involve facilitating the further development of alternatives to institutionally based long-term care (LTC), largely through waivers for states to provide home- and community-based care. One fundamental change would integrate Medicare and Medicaid for coverage of LTC needs. Inclusion of LTC benefits in a Medicare voucher system (which implicitly removes them from Medicaid) is seen as one significant factor in enhancing the acceptability of a voucher plan (Friedman et al., 1983).

Various other reforms to Medicaid have also been put forth. K. Davis (1983) proposed abolishing Medicaid for low-income elderly persons and establishing a "wraparound" policy that would cover the cost-sharing arrangements of Medicare and expand certain other benefits. In contrast, the present administration proposed (Iglehart, 1983a) that Medicaid require a copayment of $1/visit from the categorically needy ($1.50 from the medically needy) for all outpatient services, improve Medicaid collections from other third-party carriers, and extend the 3-percent reduction in the federal matching rate into future years. Others (see CBO, 1981) propose a system of vouchers for Medicaid eligibles to purchase either health insurance or membership in HMOs, but consideration of a change of this magnitude in Medicaid has tended to be delayed until experience is gained with the voucher system for Medicare.

The CBO examined some options for resolving Medicaid's cost problems and modifying its coverage of the low-income population (CBO, 1981). The main options fell into three categories targeted on modifying eligibility, benefits, reimbursement requirements, and financing arrangements. Specifically considered were (a) targeting eligibility on the most needy persons (e.g., all low-income children), eliminating eligibility for less needy individuals, or establishing a minimum national standard for eligibility; (b) changing (i.e., eliminating) benefits, expanding cost-sharing, or liberalizing reimbursement policies (e.g., greater state flexibility in rate-setting and volume purchasing through competitive bidding); and (c) limiting federal outlays (e.g., by imposing a cap on increases in expenditures) or calculating the federal share of Medicaid payments differently.

The most fundamental change proposed for Medicaid is probably the idea of "federalizing" the program, either independent of returning some other federally subsidized program to the states or as part of a package in which states would take over a program such as Food Stamps. Some persons advocate federalization as a means of covering millions of poor people who are now uninsured, instituting a uniform benefit package across the states, and introducing some major reforms in reimbursement. Others fear that federalization (by doing precisely those things) would be a first step toward a "total national health program" (Iglehart, 1982a). Political considerations and the projected levels of deficits in the federal budget for at least the next few years render this an extremely unlikely change, but proposals of this nature will no doubt continue to be debated.

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